

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Wright, Richard	Inmate Number:	187140WR
Service Authorized:	Office Visits: Outpatient Optometry Referral	Effective Dates:	02/28/2005
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Bullock Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14741367	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

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The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

Dr. Brad Bird
2-18-05

02/25/05 FRI 18:07 FAX 20594 17
02/22/2005 TUE 13:58 FAX 334 17 8755 BULLOCK CORRECTIONAL FACKINKOS HOMEWOOD
8755 BULLOCK CORRECTIONAL FAC153
02/22/05Form must be complete and legible. You must type or print.
Please send this form with the Authorization Letter to the service provider at the time of the Appointment.

1-105

DEMOGRAPHICS

Site Name & Number

Bullock 832

Site Phone #

(334) 738-5625

Site Fax #

(334) 738-8763

Will there be a charge?

☒ Yes ☐ No

For

☒ Male ☐ Female

Patient Name: (Last, First)

Wright Richard

Alias: (Last, First)

Insurance #

187140

SS Number

Dates (mm/dd/yyyy)

02/18/05

Date of Birth: (mm/dd/yyyy)

08/15/67

PCS Custody Date: (mm/dd/yyyy)

1/1/05

Potential Release Date: (mm/dd/yyyy)

10/23/20

Responsible Party:

☐ Title☐ Ass. Inc.☐ Health Ins. (Check for Medicare/Medicaid Managed Care Waiver plans)☐ Other, be specific (Check for Medicare and Medicaid)

CLINICAL DATA

Requesting Provider:

☒ M.D. ☐ N.P. ☐ Other

Facility Medical Director Signature and Date

Tom 2/22/05

☐ Service exists outside for "approval by protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS) ☐ Dialysis (DL)☐ Intake ☐ Discharge

Estimated Date of Service (mm/dd/yyyy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

Number of Visits/Treatments:

☐ Radiation Therapy☐ Chemotherapy☐ Other

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Eye exam

You must include copies of pertinent reports such as lab results,

x-ray interpretations and specialty consult reports with this form.

☐ Pertinent documents have been attached and filed.

History of Illness (History of Present Illness with Date of Onset)

Immediate Post Vision

Results of a complaint directed physical examination:

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Previous treatment and response (including medications):

Glasses

For accuracy and safety, please do not inform patient of possible follow-up appointments.

UM DETERMINATION:

☐ Alternative Treatment Plan (explain how):☐ More Information requested: (See Attached)☐ Resubmitted with requested information.☐ Unique Service Recommended and Authorized

Date recommended:

Regional Medical Director Signature,

printed name and date required:

Will Mosier, MD

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cost Type:

01/02

Med Class:

99201

UM Number:

14741367

UM Referral review form 2-05-2004

RECEIVED FEB 22 2005

DEMOGRAPHICS

Site Name & Number:

Bullock 832

Site Phone #

(334) 738-5625

Site Fax #

(334) 738-8763

Patient Name: (Last, First)

Wright Richard

Alias: (Last, First)

Inmate #

187140

SS Number

D. (mm/dd/yy)

02.18.05

Date of Birth: (mm/dd/yy)

08.15.67

PHS Custody Date: (mm/dd/yy)

1.1.1

Potential Release Date: (mm/dd/yy)

10.23.20

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS

☐ Auto Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)

☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☒ Physician

☐ NP, PA

☐ Dental

Facility Medical Director Signature and Date:

[Signature] 2/22/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)

☐ X-ray (XR)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☐ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

1.1.1

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Dr. Bradford

Type of Consultation, Treatment, Procedure or Surgery:

Eye exam

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptoms with Date of Onset:

Inmate's
Poor Vision

Results of a complaint directed physical examination:

4 vision

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Previous treatment and response (including medications):

Passes

For security and safety, please do not inform patient of possible follow-up appointments***

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted:

1.1.1

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cell Type:

Med Class:

UM Auth #:

INSTITUTIONAL EYE CARE

P.O. Box 390
Lewisburg, PA 17837

(570) 524-493
FAX (570) 524-2817

PATIENT <i>Richard Wright</i>			DATE		
NUMBER <i>187140</i>			INSTITUTION <i>BULLOCK</i>		
	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD	<i>-7.5</i>	<i>-50</i>	<i>130</i>		
OS	<i>-1.00</i>	<i>-50</i>	<i>60</i>		
	ADD	HEIGHT	DIST PD	NEAR PD	SEG STYLE
C			<i>68</i>		
OS					
LENS COLOR/COATINGS					
FRAME <i>NICK</i>		STYLE		FRAME COLOR	
EYE SIZE <i>54</i>	BRIDGE	TEMPLE	HEAT	CHEM	
DATE REC'D <i>11/10</i>		DROP BALL <i>7/16</i>		FINAL INSPECTION	

LENSES: _____

FRAME: _____

OVERSIZE: _____

TINT/PGX: _____

CHEM. TEMP. GLASS: _____

DIOPTERS: _____

S/H: _____

TOTAL DUE (\$): _____

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VISION SAFETY NOTICE:

• Your lenses meet or exceed American National Standard Z80.1 and FDA requirement 21 CFR Sec 801.410 for impact resistance but are not unbreakable or shatterproof. Of all the materials that lenses can be made from polycarbonate is the most impact resistant.

• If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area causing injury.

• The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately.

• If your occupational or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

INSTITUTIONAL EYE CARE

P.O. Box 390
Lewisburg, PA 17837

(570) 524-493
FAX (570) 524-2817

PATIENT <i>Richard Quaker</i>			DATE		
NUMBER <i>187140</i>			INSTITUTION <i>Outlook</i>		
	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD	<i>-7.5</i>	<i>+5.0</i>	<i>130</i>		
OS	<i>-1.00</i>	<i>+5.0</i>	<i>60</i>		
	ADD	HEIGHT	DIST PD	NEAR PD	SEG STYLE
OD					
OS			<i>68</i>		
LENS COLOR/COATINGS					
FRAME <i>nick</i>		STYLE		FRAME COLOR	
EYE SIZE <i>54</i>	BRIDGE	TEMPLE	HEAT	CHEM	
DATE REC'D <i>6/10</i>		DROP BALL <i>7/6</i>	FINAL INSPECTION		

LENSES: *[Signature]*FRAME: *[Signature]*

OVERSIZE: _____

TINT/PGX: _____

CHEM. TEMP. GLASS: _____

DIOPTERS: *7.5*S/H: *[Signature]*TOTAL DUE (\$): *14.95***VISION SAFETY NOTICE:**

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• If your occupational or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

EYE EXAMINATION SHEET

TO: (Service Physician) <i>Dr. Bradford</i>	FROM: (Requesting Ward, Med. Fac. Phys.) <i>Bullock</i>	Date of Request: <i>5/31/99</i>
Reason For Request: (Complaints and Finding) <i>unable to see things faraway</i>		
Past History <i>Received state glasses 3 years ago</i>		
Old Rx Signature		Type of Consult <input type="checkbox"/> Emergency <input type="checkbox"/> Routine
CONSULTATION REPORT		
Subjective: OD <i>20/40</i> OS <i>20/70</i>		OPHTH: <i>50% c/d/wNL</i>
New Rx: OD OS	Seg. Ht.	Ext: Date Dispensed & Initials:
Seg. Type: <i>250 - 075 - 050 x 130 / f7w</i> <i>250 100 050 060 68</i>		
IDP & Time: Frame: Size: Color:		
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <i>14/14</i> <i>Noted by p. 6/1/99</i> </div> <div style="width: 40%; text-align: right;"> <i>54/18/145</i> </div> </div>		
FOR PROFESSIONAL USE ONLY CONFIDENTIAL RECORD NOT TO BE PHOTO COPIED OPTOMETRIST'S SIGNATURE		
Patients Last Name <i>Wright</i>	First <i>Richard</i>	Middle Age <i>B/M 32</i>
R/S <i>187/40</i>		I D No.

INSTITUTIONAL EYE CARE

P.O. Box 390
Lewisburg, PA 17837

(717) 523-3493
FAX (717) 524-2817

PATIENT <u>WRIGHT, Richard</u>			DATE		
NUMBER <u>187140</u>			INSTITUTION <u>Stanton AL</u>		
	SPHERE	CYLINDER	AXIS	PRISM	BASE
OD	<u>-1.5</u>	<u>-2.5</u>	<u>155</u>		
OS	<u>-5.0</u>	<u>-5.0</u>	<u>33</u>		
	ADD	HEIGHT	DIST PD	NEAR PD	SEG STYLE
OD			<u>68</u>		

LENS COLOR/COATINGS

FRAME <u>WICK</u>	STYLE	FRAME COLOR		
EYE SIZE <u>54</u>	BRIDGE	TEMPLE	HEAT	CHEM
DATE REC'D <u>9/19/97</u>	DROP BALL		FINAL INSPECTION	

LENSES: 9.15FRAME: 2.15

OVERSIZE: _____

TINT/PGX: _____

CHEM. TEMP. GLASS: _____

DIOPTERS: _____

S/H: 1.15TOTAL DUE (\$): 14.95

SAFETY NOTICE:

• Your lenses meet or exceed American National Standard Z80.1 and FDA requirement 21 CFR Sec 801.410 for impact resistance but are not unbreakable or shatterproof. Of all the materials that lenses can be made from polycarbonate is the most impact resistant.

• If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye, or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area causing injury.

• The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately.

• If your occupational or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special safety spectacles with safety lenses, side shields, goggles and/or a full face shield.

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EYE EXAMINATION SHEET

TO: (Service Physician) <i>Bradford</i>	FROM: (Requesting Ward, Med. Fac. Phys.) <i>Diaperes Con. Center</i>	Date of Request: <i>8/15/96</i>
Reason For Request: (Complaints and Finding) <div style="text-align: center; font-size: 2em;"><i>NA / No SE</i></div>		
Past History		
Old Rx		
Signature	Type of Consult <input type="checkbox"/> Emergency <input type="checkbox"/> Routine	

CONSULTATION REPORT

Subjective: OD - *20/40 5 lines*
 OS - *20/30*

-075 -025 135

New Rx: OD *050 050 + 033*
 OS *050 050 + 033*

Seg. Ht. *68*

Seg. Type: *54/18/145*

IDP & Time:

Frame:
Size:
Color:

OPHTH: *406* *rg*
rm

Ext:
Date Dispensed & Initials:

EW

68

54/18/145

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MZ

OPTOMETRIST'S SIGNATURE

Patients Last Name <i>Wright</i>	First <i>Richard</i>	Middle	Age <i>29</i>	R/S	ID No. <i>187140</i>
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KILBY CORRECTIONAL FACILITY

PO BOX 11

MT. MEIGS, AL 36057

PATIENT NAME

Wright, Richard

PRISON ID

187140

DATE SUBMITTED

5-5-05

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VCF 78

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY	NR	NEGATIVE (NEG)	
RPR	NR	NON-REACTIVE (NR)	
URINALYSIS			
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A" These results are unreliable due to the age of the specimen.

"H" These results are unreliable due to the hemolyzed condition of the specimen.

"A+H" These results are unreliable due to the age and hemolyzed condition of the specimen.

Wright, Richard
ID: 187140

04/26/2005 6:54:02

SINUS BRADYCARDIA
NO OTHER FINDING

D.O.B.: 08/15/1967 37 YEARS

MALE

Meds:

Class:

Dr: Rayapati

Tech: LMC

Vent. Rate: 59 bpm
RR Interval: 1004 ms
PR Interval: 182 ms
QRS Duration: 90 ms
QT Interval: 424 ms
QTc Interval: 423 ms
QT Dispersion: 58 ms
P-R-T AXIS: 66° 68° 38°

Summary: NORMAL ECG EXCEPT FOR RATE * Unconfirmed Analysis *

Comment: AYP

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[Handwritten signature]

